FORM APPROVAGE POMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING **B. WING** 085029 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET HARRISON HOUSE OF GEORGETOWN **GEORGETOWN. DE 19947 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 000 **INITIAL COMMENTS** F 000 **Disclaimer Statement** An unannounced annual survey and complaint Preparation and /or execution of the visit was conducted at this facility March 18, 2009 Plan of Correction does not constitute through March 25, 2009. The facility census on admission or agreement of the provider the first day of survey was one hundred-four of the truth of the facts alleged or (104). The deficiencies contained in this report conclusions set forth in the Statement are based on observations, interviews, review of of Deficiencies. The Plan of Correction residents' clinical records and review of other is prepared and /or executed solely facility documentation as indicated. The survey because it is required by the provisions sample totaled twenty-one (21) residents, of federal and state law. eighteen (18) active and three (3) closed records respectively. There were an additional five (5) This plan represents the facility's credible sub-sampled residents for interview purposes allegation of compliance as of 6/01/09. 6/01/09 only. F 157 483.10(b)(11) NOTIFICATION OF CHANGES F 157 SS=D 483.10 (b) (11) Notification of Changes A facility must immediately inform the resident: consult with the resident's physician; and if The facility will immediately consult with known, notify the resident's legal representative the resident's physician in the event of a or an interested family member when there is an significant change in the resident's physical, accident involving the resident which results in mental or psychosocial status. injury and has the potential for requiring physician intervention; a significant change in the resident's To address survey concerns the facility is taking the following measures: physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or One: Corrective action for situation clinical complications); a need to alter treatment identified · significantly (i.e., a need to discontinue an existing form of treatment due to adverse The facility recognizes that there is no consequences, or to commence a new form of corrective action for the concern identified treatment); or a decision to transfer or discharge for R2 from 11/25/09 to 11/27/09. The facility the resident from the facility as specified in has continued to consult, in a timely manner, with the resident's physician with regards §483.12(a). to the resident's condition. On-going The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Carole

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

aniels

TITLE

Administr

(X6) DATE

271

### PRINTED: 04/17/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 085029 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET HARRISON HOUSE OF GEORGETOWN **GEORGETOWN, DE 19947** (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION ID (X5) **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 157 Continued From page 1 F 157 Two: Identification of other residents resident rights under Federal or State law or that have the potential to be affected regulations as specified in paragraph (b)(1) of The facility recognizes that all residents have this section. the potential to be affected with regards to immediate physician notification in the event The facility must record and periodically update of a change in condition. Daily the QI nurse the address and phone number of the resident's or the nurse supervisor reviews the Nurse legal representative or interested family member. 24 hour report and nursing documentation to ensure that the physician has been notified for any resident status change. This REQUIREMENT is not met as evidenced. bv: Based on interviews and record reviews it was Three: Measures or systemic changes determined that the facility failed to immediately notify the resident's physician for one (R2) out of In addition to the daily review by the OI nurse 21 sampled resident who had a significant or supervisor of changes in resident condition change in condition. Findings include: or status, the policy and procedure has been updated, in accordance with F tag 157. All Cross refer F327 and F329. nursing staff will be inserviced on the Change in Resident Status Policy and Procedure by Review of R2's November 2008 meals 5/22/09. percentage record indicated from 11/18/08

F 252

SS=B

sent to the hospital via 911.

483.15(h)(1) ENVIRONMENT

The facility must provide a safe, clean.

period of time.

through 11/24/08, the resident's fluid intake varied from none to 480 cc per day. Beginning on 11/25/08 at lunch through lunch on 11/29/08

(approximately 13 meals), the resident consumed a total of 240 cc of fluids during this four day

Review of nurses notes on 11/25/08, 11/26/08.

physician was notified of the resident not taking

almost anything by mouth for this period of time.

The record documented that on 11/29/08 timed 1:30 PM the resident was unresponsive and was

and 11/27/08 lacked evidence that R2's

F 252

Attachment 🗡

Four: Monitoring Mechanisms

The QI nurse will continue to audit

483.15(h)(1) Environment

resident records to ensure compliance with regards to timely physician notification

and follow up. Concerns will be reported to

measures in accordance with facility policy.

Results of the QI audit will be reported at the monthly and quarterly QI meeting,

the nurse manager who will take the appropriate

5/22/09

On-going

PRINTED: 04/17/2009

EPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM AF AB NO. <u>0</u>	PROVED <u>938-0391</u>
ATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIERICLA (DENTIFICATION NUMBER:	(X2) N	7	LE COMSTRUCTION	DATE SUR COMPLETE	VEY
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. "	OVIDER OR SUPPLIER	. <del>_</del> .		STRI 11	EET ADDRESS, CITY, STATE, ZIP CODE IQ W. NORTH STREET		
IARRISC	N HOUSE OF GEO!	GETOWN		G	EORGETOWN, DE 19947		
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F 252	the resident to use to the extent poss.  This REQUIREMS by: Based on observanceord review and determined that the	omelike environment, allowing his or her personal belongings	F	252	The facility will provide a clean and homelike environment and will mainta resident equipment in proper operating condition.  To address survey concerns the facility undertaking the following measures:  One: Action taken to situation identified the over bed tables in room# 50, 48, 421 that were noted to have veneer dam will be replaced.	y is ified:	5/15/09
F 327 SS=6	include:  1. The over bed 21 had veneer da particle board wa is difficult to clear made the tables of past purchase or stands were prodreplacement but of over bed table: 03/25/09, for six other furniture, w furniture replacer interview indicate occurring at a rat quarter.  483.25(j) HYDR/	cables of rooms #50, 48, 47, and mage such that the underlying is showing. This type of material is and keep sanitary. It also unsightly as they were damaged, ders for chairs and bed side used as evidence of furniture acked evidence of replacement is. A purchase requisition, dated over bed tables, in addition to as offered as evidence of ment for the current survey. Staff id that furniture replacement was the of six furniture items per			Two: Identification of other resident have the potential to be affected.  The facility recognizes that all resident the potential to be affected with regard the provision of a clean and homelike environment.  Three: Measures or systemic change improperly operating equipment will replaced as needed and on a routine before: Monitoring Mechanisms  As part of the facility's preventative maintenance program the maintenance department will conduct an audit of neutral functions will be addressed immediate Results of the audit will be reported as	ges ged or be pasis.  ce resident y noted tely. at the	Ongoing
	by: Based on record	MENT is not met as evidenced review and staff interviews, it that the facility failed to ensure		F 327	monthly and quarterly QI committee. 483.25(j) Hydration	·	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
	085029	B. WIN	1G _		1	C 5/2009
	GETOWN		1	10 W. NORTH STREET		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
that one (R2) out of provided with suffice proper hydration and identify the increased (with known risk for resident had only 2 fluids during a four failed to respond in resident's inadequate resident being admitted to diagnoses including coronary artery discrenal failure (CRF). The initial Minimum dated 9/19/08 indict moderately impaired and required superthe resident required eating.  The admission blood 9/16/08 indicated the initrogen (BUN) leverange 8-23 mg /dl) was elevated at 2.0 In addition, the sood 138 (normal range creatinine, and sod fluid imbalance and the registered dietication in the r	f 21 sampled residents was ient fluid intake to maintain id health. The facility failed to ed risk of dehydration for R2 dehydration) when the 40 cc (cubic centimeters) of day period of time. The facility a timely manner to the ite fluid intake resulting in the ited to the hospital where she abnormal laboratory values indings include:  If the facility on 9/12/08 with g dementia, hypertension, ease, osteoporosis, chronic and hypothyroidism.  If Data Set (MDS) assessment ated that the resident was d for daily decision making vision and cuing. In addition, and supervision and set-up for od work at the facility dated that the resident's blood ureated was elevated at 32 (normal and that the creatinine level (normal range 0.6-1.5 mg/dl), item level was within normal at 135-145 mmOL). BUN, item levels are indicators of itemal function.  Initial nutritional assessment by cian dated 9/18/08	F	327	The facility will continue to ensure to residents are provided with sufficient intake to maintain proper hydration health, identify those at risk for dehy and respond in a timely manner to it fluid intake which could result in a condition.  To address survey concerns the facilitaking the following measures:  One: Corrective Action for situat identified  The facility recognizes that there is corrective action for the concerns id However upon R2s return to the fact following measures were implement plan for risk for dehydration, Intake Output, medication review by phys Speech and OT evaluation for swall feeding, Psych evaluation for behave medication review and consultant Preview.  Two: Identification of other reside have the potential to be affected  The facility recognizes that all resid the potential to be affected by the rist to insufficient fluid intake, dehydrat timely care intervention.  Continued review of the daily 24 ho and facility documentation by the QI nurse or nursing manager has rethe timely identification of any residential intervention.	at fluid and dand dand dand dand dand dand dan	
	ROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From pa that one (R2) out of provided with suffic proper hydration an identify the increase (with known risk for resident had only 2- fluids during a four failed to respond in resident's inadequa resident being adm was found to have and dehydration. F  R2 was admitted to diagnoses including coronary artery disc renal failure (CRF),  The initial Minimum dated 9/19/08 indic moderately impaire and required super the resident require eating.  The admission bloc 9/16/08 indicated th nitrogen (BUN) leve range 8-23 mg /dl) was elevated at 2.0 In addition, the sod 138 (normal range creatinine, and sod fluid imbalance and The review of the in the registered dietic documented reside	ROVIDER OR SUPPLIER  ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 that one (R2) out of 21 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to identify the increased risk of dehydration for R2 (with known risk for dehydration) when the resident had only 240 cc (cubic centimeters) of fluids during a four day period of time. The facility failed to respond in a timely manner to the resident's inadequate fluid intake resulting in the resident being admitted to the hospital where she was found to have abnormal laboratory values and dehydration. Findings include:  R2 was admitted to the facility on 9/12/08 with diagnoses including dementia, hypertension, coronary artery disease, osteoporosis, chronic renal failure (CRF), and hypothyroidism.  The initial Minimum Data Set (MDS) assessment dated 9/19/08 indicated that the resident was moderately impaired for daily decision making and required supervision and cuing. In addition, the resident required supervision and set-up for	ROVIDER OR SUPPLIER ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 that one (R2) out of 21 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to identify the increased risk of dehydration for R2 (with known risk for dehydration) when the resident had only 240 cc (cubic centimeters) of fluids during a four day period of time. 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In addition, the sodium level was within normal at 138 (normal range 135-145 mmOL). BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function.  The review of the initial nutritional assessment by the registered dietician dated 9/18/08 documented resident consumed less than 50% of	ROVIDER OR SUPPLIER  TON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 that one (R2) out of 21 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to identify the increased risk of dehydration for R2 (with known risk for dehydration) when the resident had only 240 cc (cubic centimeters) of fluids during a four day period of time. 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BUN, creatinine, and sodium level was within normal at 138 (normal range 6 registered dietician dated 9/18/08 of the implementation of any residrisk and the implementation of apprainterventions.	ROVIDER OR SUPPLIER  N HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY)  SUMMARY STATEMENT OF DEFICIENCY  FEORD SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  FEOVOERS PLAN OF CORRECTION  [RECH CORRECTION DEFICIENCY  FROVDERS PLAN OF CORRECTION  [RECH CORRECTIVE ACTION OF CRECTION  [RECH CORRECTIVE ACTION OF CRECTION  The facility will continue to ensure that all residents all residents and Intelligity and Intelligent on the Recility of the design of the development of the develo

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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·		085029				03/2	5/2009
	PROVIDER OR SUPPLIER ON HOUSE OF GEOR	GETOWN		1'	EET ADDRESS, CITY, STATE, ZIP CODE 10 W. NORTH STREET ECORGETOWN, DE 19947	_	
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F 327	requirement was 1, Risk Screen" dated resident as "potenti implement a care p of less than 75%.  Review of the facilit risk assessment" in will be completed u significant change ophysical or mental risk assessment da and had missing in consumed" and "flu supplements", how assessed as low ris assessment was continued to assess though the resident	400 cc. The initial "Nutrition 9/18/08 assessed the al risk." The plan was to lan to address R2's oral intake by's policy titled "dehydration dicated that the assessment pon admission or when a occurs in the resident's status. The initial dehydration sted 9/12/08 was incomplete formation/scores for "food dids consumed including ever, the resident was sk. Subsequent re-admission ompleted on 12/5/08 and as the resident as low risk even was discharged from the condary discharge diagnosis	F	327	Three: Measures or systemic change To address the survey concerns the faimplementing the following Policies: Procedures by 5/22/09:  1. HYDRATION RISK ASSESSME HYDRATION RISK EVALUATE Attachment   2. CHANGE IN RESIDENT STATU Cross reference POC F 157  Attachment   3. MEDICAL VISIT/FOLLOW-UP Cross reference POC F 501  Attachment   4. INTAKE MONITORING	acility is and ON	5/22/09
	The resident's care plan for "Risk of dehydration" was implemented on 9/15/08 which included the following approaches:  - Monitor labs as available  - Encourage fluids especially between meals and at bedtime.  - Monitor for signs and symptoms of dehydration and notify nursing and MD: fever, change of LOC (level of consciousness), change in behaviors, poor skin turgor, decrease urinary output, confusion, concentrated urine, etc.  - Dietary/SLP (Speech Language Pathologist) consult PRN (as needed)  - Monitor weight  The care plan review dates were documented as 12/11/08 and 3/5/09, however, no revision in approaches were noted. In addition, the				DAILY MEAL MONITORING TEMPORARY CARE PLAN Inadequate Intake  Attachment   To address meal monitoring and early intervention the nursing staff was inse on a Daily Meal Monitoring Policy are by 4/7/09. The Policy and Procedure updated on 4/22/09 to include addition assessment information.  Attachment 4/7/09   E	erviced nd form was	4/07/09

### PRINTED: 04/17/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 085029 03/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET HARRISON HOUSE OF GEORGETOWN **GEORGETOWN, DE 19947** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 327 Continued From page 5 F 327 In order to accurately include and document document did not include the estimated daily fluid all sources of intake the facility is requirement of 1,400 cc. implementing updated CNA and Nurse Intake and Output forms, effective The care plan for problem of "PO (oral intake) immediately. less than 75%", implemented by E1 on 9/18/08 included the following approaches: -Monitor PO intake daily Nursing and CNA staff were inserviced on - Snack/supplements as ordered which included the Intake and Output forms by 4/6/09 house nutritional supplement two times per day 4/06/09 Attachment 6 - 8 (oz) ounces of milk and 4 oz, of juice for all meals The care plan review dates documented were 2/24/08, 12/11/08, and 3/5/08, however, 1,400 cc To address the Dietary Referral: A daily requirement was not included in the DIETARY COMMUNICATIONS BOOK document. will contain all requests for a Dietician Consultation which the Dietician, QI nurse and/or the nurse manager will review twice a Review of the CNA "Individual meal % record" for week .All requests will be signed by the 11/17/08 revealed that the resident did not take Dietician and returned to the book. The book any food or fluids. Review of a nurse's note dated will also contain meal % sheets for reference. 11/17/08 timed 2:30 PM documented that the This measure will assist in ensuring the attending physician was notified of the decrease maintenance of proper hydration. This is in oral intake and no new order was received. In effective immediately. addition, a referral to the dietician was sent. Although the above nurse's note indicated a The RNAC COMMUNICATION FORM will continue to be utilized whenever a dietary referral, record review lacked evidence change in care level or care interventions has that the dietician was consulted. An interview E1 occurred. This will ensure accurate and on 3/23/09 at 11:30 PM revealed that the referral timely care planning documentation. was not received by the E1, thus, not completed. Attachment H Review of the physician's progress note dated

11/18/08 noted "poor PO intake few days. She is

either awake and restless or sedated. No c/o

(complaint offered) and no pain." In addition,

(failure to thrive) /Decrease PO (oral intake) ? (questionable) etiology" and the plans included

blood work and to increase PO fluids.

assessment and plan was documented as "FTT

Event ID: JGNS11

5/22/09. Attachment *I* 

All nursing services staff will be inserviced

on the above Policies and Procedures by

5/22/09

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		085029	B. WII	NG		1	C 25/2009
NAME OF PROVIDER HARRISON HOU		GETOWN		11	EET ADDRESS, CITY, STATE, ZIP CODE		
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Orders include - Hold pressure - CBC, - Hold pressure treat his - Media - Hold letharg - Enco - Althour follow-eviden design - The sure indicate levels - Creatin - Nurse' documedical Mylant - Trama to severe - 11/26/document -	ed the following Lisinopril (more) BMP, Mg, F Lopressor are) lower that igh blood precal follow-up Risperdal (not provided that the area ee re-evaluation refusal as 30 cc. PO and HCL (Ultere pain) PC and the form 11/24 pented Lopressor are wof the Medical from 11/24 pented Lopressor are wof the Medical from 11/24 pented Lopressor are wof the Medical from 11/24 pented Lopressor are absent are wof the Medical from 11/24 pented Lopressor are are wof the Medical from 11/24 pented Lopressor are are are form 11/24 pented Lopressor are are form 11/24 pented Lopressor are are form 11/24 pented Lopressor are formatted are formatt	adding physician on 11/18/08 ing: edication to treat high blood  Phos. in AM (blood work) and Catapress if B/P (blood an 120 (both medications to essure) one week nedication to treat dementia) if  aids  e order indicated "medical eek", record review lacked attending physician or the ated the resident's condition.  cood work dated 11/19/08 esident's sodium and BUN ed at 147 and 34 respectively. In normal range at 1.2.  I 11/24/08 not timed ding physician aware of and order was receive for TID (three times per day) and tram, medication for moderate	F	327	Four: Monitoring Mechanisms:  Unit manager or designee will be refor the daily monitoring of residenthe timely consultation with the phany change of condition. The unit designee will continue to report to interdisciplinary team the daily rescondition utilizing the nurse 24 ho The QI nurse will continue to audi 24 hour report and any pertinent redocumentation. Any identified cobe addressed immediately and report and any and the provision by a nurse rewill continue to assist in the provisionality, timely care.  The QI review results will be reported to the provision of the provis	responsible t care and hysician of manager or the sident four report. It the daily fored the fored the fore. fored to the forted to the	On-going

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER  HARRISON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LSS (DEMIN'S MARCH	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
HARRISON HOUSE OF GEORGETOWN    Marking   Mark	-		085029	B. WIN	IG		1	
RECORD DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  F 327  Continued From page 7 than 120. In addition, "Encourage PO" was transcribed and signed off by the staff nurses.  Review of the November 2008 meals percentage record indicated from 11/18/08 through 11/24/08, the resident's fluid intake varied from none to 480 cc per day. Beginning on 11/25/08 at lunch through lunch on 11/29/08 (approximately 13 meals), the resident consumed total of 240 cc of fluids during this four day period of time.  An interview with the Director of Nursing (E2), Assistant Director of Nursing (E3), and the Unit Manager (E4) on 3/24/09 at 10:30 AM revealed that the resident's behaviors affected their ability to encourage fluids.  Review of the "24 hours Supervisory Report" dated 11/26/08 indicated that a dietary communication was done for a sippy cup; an assistive device. Record review lacked evidence when this assistive device was obtained, utilized, and above care plans failed to include this intervention to assist with increasing fluid intake, therefore it was unclear if staff knew when to use this device.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident had not taken any oral fluids for three days (11/26/08, 11/27/08, and 11/28/08), resident noted with letharry, easily acoused. Risperdal and Depakote held, 4B 28/2680-(The covering physician). E7 ordered to increase Remeron (medication to treat depression) from 7.5 mg. to			RGETOWN		11	0 W. NORTH STREET	DE .	
than 120. In addition, "Encourage PO" was transcribed and signed off by the staff nurses.  Review of the November 2008 meals percentage record indicated from 11/18/08 through 11/24/08, the resident's fluid intake varied from none to 480 cc per day. Beginning on 11/25/08 at lunch through lunch on 11/29/08 at lunch through lunch on 11/29/08 at lunch through lunch on 11/29/08 (approximately 13 meals), the resident consumed total of 240 cc of fluids during this four day period of time.  An interview with the Director of Nursing (E2), Assistant Director of Nursing (E3), and the Unit Manager (E4) on 3/24/09 at 10:30 AM revealed that the resident's behaviors affected their ability to encourage fluids.  Review of the "24 hours Supervisory Report" dated 11/26/08 indicated that a dietary communication was done for a sippy cup; an assistive device. Record review lacked evidence when this assistive device was obtained, utilized, and above care plans failed to include this intervention to assist with increasing fluid intake, therefore it was unclear if staff knew when to use this device.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident had not taken any oral fluids for three days (11/28/08, 11/27/08, and 11/28/08), resident noted with lethargy, easily aroused. Risperdal and Depakote held. (EP 8/2/680/(The covering physician), E7 was made aware of the above findings, however, the resident was not seen by the physician). E7 ordered to increase Remeron (medication to treat depression) from 7.5 mg. to	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
	F 327	than 120. In additi transcribed and signal record indicated from the resident's fluid cc per day. Begins through lunch on 1 meals), the resident fluids during this formal fluids during this formal fluids during the fluids during this formal fluids during the fluids days of the "24 dated 11/26/08 incommunication was assistive device. In when this assistive and above care planter vention to assist therefore it was unthis device.  Subsequent "24 had 11/28/08 for the 3 resident had not to days (11/26/08, 13 noted with letharg and Depakote helphysician, E7 was findings, however, the physician). E7 (medication to tree fluids)	on, "Encourage PO" was gned off by the staff nurses.  ember 2008 meals percentage om 11/18/08 through 11/24/08, intake varied from none to 480 ning on 11/25/08 at lunch 11/29/08 (approximately 13 nt consumed total of 240 cc of our day period of time.  the Director of Nursing (E2), of Nursing (E3), and the Unit 3/24/09 at 10:30 AM revealed behaviors affected their ability s.  hours Supervisory Report" dicated that a dietary as done for a sippy cup; an Record review lacked evidence e device was obtained, utilized, ans failed to include this sist with increasing fluid intake, inclear if staff knew when to use ours Supervisory Report" dated PM to 11 Shift indicated aken any oral fluids for three 1/27/08, and 11/28/08), resident y, easily aroused. Risperdal d. BP 82/680. (The covering made aware of the above, the resident was not seen by 7 ordered to increase Remeron at depression) from 7.5 mg. to		327			

Event ID: JGNS11

PRINTED: 04/17/2009 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULT!PL LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
•		085029	B. WI	NG			5/2009
	ROVIDER OR SUPPLIER ON HOUSE OF GEOF	RGETOWN		110	ET ADDRESS, CITY, STATE, ZIP CODE OW. NORTH STREET CORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 327	revealed that anoth in R2's care when lethargic on 11/28	age 8 medical director, E5 on 3/24/09 her physician, E7 was involved the resident was reported to be //08 and has not discussed the to the hospital confinement.	F	327			
	intake and output PM to 7 AM shift of shifts after the resignificant by mouthe resident continuation and had on PM shift on 11/29/	ealed that the facility initiated (I&O) monitoring during the 11 on 11/28/08, approximately eight ident stopped taking anything th. Monitoring indicated that used not to take anything by ally voided one time on 7AM to 3 /08 with no other output from 5 7 AM shift through 11/29/08 ft.		-			
·	AM revealed that Meal % Record" is did not reveal what resident is not tak addition, both E2	E2 and E3 on 3/24/09 at 10:30 on a daily basis, the "Individual s reviewed, however, interview at was expected by staff when a ing anything by mouth. In and E3 revealed that the facility solicy for when to initiate D.					
	documented "B/P	d 11/29/08 timed 1 AM 122/74, continues to be alert enough to have any intake.					
	1:30 PM stated recues and touch, E	se's note dated 11/29/08 timed esident unresponsive to verbal B/P 80/40, and the physician was e resident was sent to the					
	Record review re dated 11/29/08 fo	vealed a "Temporary care plan" or the problem of lethargy and					

(X2) MULTIPLE CONSTRUCTION

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	_	C
		085029	B. WING			5/2009
	OVIDER OR SUPPLIER	GETOWN	11	EET ADDRESS, CITY, STATE, ZIP 10 W. NORTH STREET EORGETOWN, DE 19947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	approaches: Monitor heart rate, Monitor heart rate, Monitor alertness: Monitor alertness: Hold medications: Follow-up with print Although R2 had a and mental status: and eventually alm decreasing B/P, the signs and sympton resident. Thus, fai manner.  Review of the hosp from 11/29/08 time pulse of 110 beats of 98.6 F. In addition creatinine and sod 3.4, and 153 respect Review of the hosp indicated the follow 1. Acute renal fails secondary to poor 2. Dehydration se 3. Toxic encephal narcotics.  On 12/5/08, the da hospital and return	which included the following respiration, blood pressure for and orientation for decrease in LOC mary care provider  significant change in physical as noted above with decrease ost no oral intake and e facility failed to identify the ns of dehydration for this led to intervene in a timely  bital emergency room records and 6 PM noted B/P 106/55, per minute, and temperature ion, the resident's BUN, item levels increased to 123, actively.  bital discharge summary ving discharge diagnoses: the with hypernatremia oral intake for four days, condary to oversedation opathy with intolerance for any of discharge from the into the facility, the resident's	F 327			
	resident's baseline respectively.	and sodium returned to e of 28, 1.2, and 142 riewed with E2, E3, and E6 on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		005020	A. BUILDIN B. WING		C 03/25/2009	
	ROVIDER OR SUPPLIER	085029	1	REET ADDRESS, CITY, STATE, ZIP CODE 10 W. NORTH STREET SEORGETOWN, DE 19947	03/23/2009	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 329 SS=D	Each resident's drunnecessary drugs drug when used in duplicate therapy); without adequate rindications for its unadverse conseques should be reduced combinations of the Based on a compresident, the facilit who have not used given these drugs therapy is necessars diagnosed and record; and resided drugs receive grad behavioral interversidents.	ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose or discontinued; or any	F 329	The facility will continue to ensure the are free from unnecessary drugs.  Cross refer F327  One: Corrective action for situation  The facility recognizes that there is no corrective action for the concerns ider during the period prior to R2 hospitali Upon return to the facility form the hofollowing measures were initiated:  1. Physician medication review. 2. Pharmacy medication review. 3. Advance directive-no tube 4. Dietician review-12/11/08. 5. Psychiatric Nurse consultat 1/09/09 6. Comprehensive Lab work of and reviewed by physician 7. TCP initiated to include we and lethargy 8. Inservice Training on "Nut Dementia" 1/19/09  Two: Identification of other reside have the potential to be affected	identified ofurther ntified ization. ospital the w w feeding 12/17/08 ion- completed sight loss rition and	
	by: Based on record in hospital records it failed to ensure the resident was free had experienced and mental status intake, decline infacility failed to entresident's medical	eview, interview, and review of was determined that the facility at one (R2) out of 21 sampled from unnecessary drugs. R2 a significant change in physical including a decline in oral vital signs, and lethargy. The asure adequate monitoring of a tion regime and failed to y significant adverse		The facility recognizes that all reside potential to be affected with regards that residents who use antipsychotic receive gradual dose reductions, and interventions, unless clinically contrain an effort to discontinue these drug	to ensuring drugs behavioral aindicated.	

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		085029	B. WING_		03/25/2009
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	•
HARRISC	N HOUSE OF GEOR	GETOWN		110 W. NORTH STREET GEORGETOWN, DE 19947	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFD BE COMPLETION
F 329	Continued From pa		F 329	Three: Measures or systemic change	es
	being hospitalized to oversedation wh	th resulted in the resident due to dehydration secondary ich required the administration her comatose state. Findings		A Temporary Care Plan (TCP) will be to monitor residents who are having de intake, (utilizing the Daily Resident M Monitoring Form) and are on a psychomedication. Effective Immediately.	ecreased
	Cross refer F327.			Attachment D	
	11/28/08, period of had significant decresident was admirmedications to ma - Depakote Sprinklused for R2 to maitimes per day. Six administered Klonopin (an anti R2 to manage behmorning. Two out - Remeron (an antimg. daily at bedtin administered Risperdal Solutato manage R2 beh PM. Five doses o - Risperdal Solutato Insperdal Solutato Insperior Insperior Insperdal Solutato Insperior Insperio	-seizure medication used for lavior) 0.25 mg. daily in the of three doses administered. i-depression medication) 7.5 me. Four out of four doses b (antipsychotropic medication lavior) 0.5 mg. at 9 AM and 4 ut of eight administered. b 1 mg. at bedtime. Three out		A TCP will be initiated for residents w starting the use of a new psychotropic medication or an adjusted dosage of psychotropic medication, to monitor to a new or adjusted dosage, level of consciousness, and overall side effects used or adjusted psychotropic medicat.  The consultant pharmacist will be inforesidents with decreased intake and wirequested to conduct a psychotropic medicat. The monthly and quarterly "Psychotropic Drug Usage Report" coby the QI nurse will be modified and a provide more detailed information to inames of residents using two or more psychotropic medications.  The use of the "Hydration Risk Assesswill be continued.	olerance to s of newly ions.  formed of ill be nedication onducted will include  5/22/09
	of four doses adm	inistered. avior/Intervention Monthly Flow		will be continued.  Cross refer F327  Attachment <u>B</u>	5/22/09
	Record from 11/2 12 shifts) revealed exhibited by R2:	5/08 through 11/28/08 (total of the following behaviors were level): 3 PM to 11 PM shifts		The use of the Behavior/Intervention Flow Record and the Behavior Logs v continued.  AttachmentsandK	monthly will be On-going

11/27/08 and 11/28/08.

- Severe agitation (hitting): None.

on 11/25/08 and 11/26/08 documented these behaviors and Xanax 0.5 mg. was administered with positive outcome. No documented behaviors

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085029			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			C	
		085029	10. ****			03/2	5/2009
	ROVIDER OR SUPPLIER ON HOUSE OF GEOR	GETOWN		11	EET ADDRESS, CITY, STATE, ZIP CODE 10 W. NORTH STREET EORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OLD BE	(X5) COMPLETION DATE
F 329	11/25/08 and 11/26 behaviors and Xan with positive outcome 11/27/08 and 11/26 ln addition, R2 was (medication for most three times per day during the same for Although R2 had a intake beginning of adequately monitor regimen and failed adverse conseque Review of the "24 dated 11/28/08 for resident had not take days (11/26/08, 11 noted with lethargy and Depakote held physician, E7 was seen by the physician, E7 was seen by the physician to increase Remer Nurse's note dated documented "B/P lethargic and not a Will monitor."  The following nurse 1:30 PM stated recues and touch, Becontacted and the emergency room.	a: 3 PM to 11 PM shifts on 6/08 documented these ax 0.5 mg. was administered me. No documented behaviors 6/08.  administered Ultram derate to severe pain) 50 mg. of for ten doses out of 12 doses our day period of time.  significant decline in oral in 11/25/08, the facility failed to or the resident's medication to identify the potential inces for R2 at this time.  hours Supervisory Report" the 3 PM to 11 Shift indicated iken any oral fluids for three /27/08, and 11/28/08), resident of the example of the covering made aware, however, was not the identification of the covering made aware, however, was not identification. A new order was received	F3	29	The following inservice training will be conducted by 5/29/09:  1. "Psychotropic Medication are effects" Medical Director 2. "Behavior/Intervention Mon Record" Inservice Coordinate 3. "CNA use of the Behavior Inservice Coordinator  Four: Monitoring Mechanisms:  The usage and effectiveness of the new tools will be monitored daily by the Qlaurse managers, and staff nurses. Corraction will be implemented immediate needed. A retrospective daily documer audit by the Ql Nurse will be conducted evaluate the documentation by the nur of residents with decreased intake and psychotropic medications. Concerns we reported to the individual nurse immediates manager within 24 hours and to Committee on a monthly and quarterly	ond Side  thly Flow tor  Logs"  v TCP  I Nurse, ective ely, if entation ed to sing staff receiving will be diately, the the QI	5/29/09

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085029	B. WIN			03/25	i
	ROVIDER OR SUPPLIER		1	11	EET ADDRESS, CITY, STATE, ZIP CODE 0 W. NORTH STREET EORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334 SS=D	from 11/29/08 time pulse of 110 beats of 98.6 F. In additice creatinine and sodi 3.4, and 153 respe progress note date resident was "come early this morning." R2 was administer "improved alertnes won't open eyes."  Review of the hospindicated the follow 1. Acute renal failt secondary to poor 2. Dehydration sea. Toxic encephalmarcotics 483.25(n) INFLUE IMMUNIZATION  The facility must dethat ensure that — (i) Before offering each resident, or trepresentative recibenefits and poten immunization; (ii) Each resident immunization Octoannually, unless the contraindicated or immunized during (iii) The resident of the pulse of the	d 6 PM noted B/P 106/55, per minute, and temperature on, the resident's BUN, um levels increased to 123, ctively. The physician d 11/30/09 documented atose-developed sometime. The note further documented and Narcan and R2 noted with a after Narcan, however, still obtained intake for four days. Condary to oversedation opathy with intolerance for NZA AND PNEUMOCOCCAL evelop policies and procedures the influenza immunization, he resident's legal eives education regarding the stial side effects of the soffered an influenza oper 1 through March 31 in immunization is medically the resident has already been		334	483.25(n) Influenza and Pneumococcal Immunizations  The facility will continue to ensure th policies and procedures that the reside medical record includes documentation that indicates that the resident or the resident's legal representative was provided education regarding the benefit and potential side effects of the influe immunization.  To address survey concerns the facilities taking the following measures:	ents' on o- s enza	
	immunization; and (iv) The resident's documentation that	medical record includes at indicates, at a minimum, the				<u> </u>	

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(X3) DATE SURVEY

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	<u> </u>	c	.
		085029	B. WING _		03/25	
	PROVIDER OR SUPPLIER	RGETOWN	1 1	REET ADDRESS, CITY, STATE, ZIP CODE 10 W. NORTH STREET BEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	OULD BE	(X5) COMPLETION DATE
F 334	following:  (A) That the residence representative was the benefits and primmunization; and (B) That the resident influenza immunizations of that ensure that—  (i) Before offering immunization, each legal representative the benefits and primmunization;  (ii) Each resident immunization;  (iii) Each resident immunization, unlemedically contrain already been immunization;  (ivi) The resident of representative has immunization; and (ivi) The resident's documentation that following:  (A) That the resident contraind immunication that following:  (B) That the resident immunication of the pneumococcal immunication of the pneumoc	lent or resident's legal sprovided education regarding otential side effects of influenza lent either received the ation or did not receive the ation due to medical or refusal.  evelop policies and procedures the pneumococcal in resident, or the resident's refusal effects of the soffered a pneumococcal ess the immunization is dicated or the resident has unized; or the resident's legal is the opportunity to refuse at indicated, at a minimum, the dent or resident's legal is provided education regarding otential side effects of munization; and dent either received the munization or did not receive at immunization or did not receive at immunization due to medical	F 334	One: Corrective Action for situation Identified  Upon identification of the concern, residents R4, R8, and R21 who refused influenza immunization were educated by the nurse manager about the benefit of taking the immunization. The documentation was entered on each of the resident's Educational Record.  Two: Identification of other resident that have the potential to be affected. After conducting a record audit, the farecognized that seven additional residence were affected with regards to the failured document the educational portion of the influenza immunization refusal. All residents were educated and the documentation was entered in the medicated.  Three: Measures or systemic changes The Immunization Consent forms will be added to the Nurse Admission Pact The admitting nurse will be responsible for reviewing the risks and benefits of immunizations. On a yearly basis the resident or responsible party will be re-educated utilizing the Influenza Immunization Informed Consent form Attachments	ithe Its Its Icility Ients Ire to Its Its Icility Ients Its Its Its Its Its Its Its Its Its I	3/19/09

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG	С
		085029	B. WING _		03/25/2009
	ROVIDER OR SUPPLIER	GETOWN	1	REET ADDRESS, CITY, STATE, ZIP CODE 10 W. NORTH STREET SEORGETOWN, DE 19947	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 334	This REQUIREMED by: Based on record redetermined that for 21 residents sampleducation regarding side effects of influence include:  R4, R8 and R21 reimmunization for the Review of their records.	ss medically contraindicated or resident's legal representative limmunization.  NT is not met as evidenced eview and interview it was three (R4, R8 and R21) out of led the facility failed to provide g the benefits and potential enza immunization. Findings fused the influenzane 2008 - 2009 flu season. ords lacked evidence that the ucation about the benefits of	F 334	Four: Monitoring Mechanisms:  An inservice will be provided to educa Nursing staff on the utilization of the Influenza and Pneumococcal Immuniz Consent forms and the Immunizations and Procedure by April 30, 2009. More during the influenza season and quarte an audit of the immunization documen will be conducted by the QI nurse. Reswill be reported at the monthly and que QI meeting. Any immediate concerns corrected immediately and reported to ADON who will ensure compliance.  Attachment	ration Policy nthly orly station sults arterly will be
F 501 SS=G	confirmed that ther residents were edu of the influenza imma revealed that the fa and potential side of upon admission whowever, this is not the residents.  483.75(i) MEDICAL	esignate a physician to serve	F 501	483.75(i) Medical Director  Cross-refer to F327	
· 24	implementation of	or is responsible for resident care policies; and the dical care in the facility.		The facility will continue to consult will Medical Director with regards to the conformal of resident care.	

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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
4		005000	B. WIN			1	C 5/2009
NAME OF P	ROVIDER OR SUPPLIER	085029		STR	EET ADDRESS, CITY, STATE, ZIP CODE	03/2	3/2003
	ON HOUSE OF GEOF	RGETOWN		11	IO W. NORTH STREET EORGETOWN, DE 19947		
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION
F 501	Continued From pa	age 16	F	501	To address survey concerns the facility is taking the following measures:		
	This REQUIREME by:	NT is not met as evidenced			One: Corrective action for situation identified		
	Based on interview determined that the Medical Director to out of 21 residents Director was not not the coordination of had no oral intake lethargic which resfor dehydration. F R2 was evaluated facility's Medical Director poor PO intake for restlessness or sedated 11/18/08 do plan as "FTT (failuintake)? (questior included blood wo	vs and record reviews, it was e facility failed to involve the coordinate care for one (R2) sampled. The Medical otified and was not involved in care for R2 when the resident for three days, became sulted in R2 being hospitalized			The facility recognizes that there is no further corrective action with regards to medical follow-up, physician consultation or assessment for R2 from 11/19/09 to 11/28/09. On 11/28/09, the on-call physician was notified of the resident's condition.  Two: Identification of other resident that have the potential to be affected. The facility recognizes that all resident have the potential to be affected by timedical follow-up and coordination. Described to the Potential to the affected by the Q or nurse supervisor will ensure that a recondition has been evaluated by the pland timely follow-up has occurred and documented.  Three: Measures or systemic change.	ts Its Its Its Its Its Its Its Its Its I	On-going
	included the follow - Hold Lisinopril (n pressure) - CBC, BMP, Mg, - Hold Lopressor a	ring: nedication to treat high blood  Phos. in AM (blood work) and Catapress if B/P (blood an 120 (both medications to essure)			Physician's orders and progress notes will be reviewed by the unit nurse. An requiring medical follow-up will be act to the Medical Visit Follow-up List to in the physician's notebook.  This procedure will ensure that the phis notified of the need for a resident viassessment.	lded ocated ysician	
		medication to treat dementia) if			Attachment C		5/22/09
	Although the abov	e order indicated "medical					

					FORM OMB NO.	
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLE	TED C
ROVIDER OR SUPPLIER			110	W. NORTH STREET	03/2.	
(FACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	• -	FACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
follow-up in one we evidence that the a designee re-evaluation one week.  Review of the their 11/25/08 at lunch to (approximately 13 consumed total of day period of time.  Subsequent "24 ho 11/28/08 for the 3 resident had not ta days (11/26/08, 11	neek", record review lacked thending physician or the lated the resident's condition in meals percentage record from hrough lunch on 11/29/08 meals) revealed the resident 240 cc of fluids during this four ours Supervisory Report" dated PM to 11 Shift indicated ken any oral fluids for three /27/08, and 11/28/08), resident	F 5	501	Nurse manager or designee of any chain condition as indicated in the Reside Status Change Policy and Procedure. Attachment	nge nt  call r or ner to  these	5/22/09
	ROVIDER OR SUPPLIER  ON HOUSE OF GEOR  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa follow-up in one we evidence that the a designee re-evalua one week.  Review of the the r 11/25/08 at lunch ti (approximately 13 consumed total of day period of time.  Subsequent "24 ho 11/28/08 for the 3 resident had not ta days (11/26/08, 11	ROVIDER OR SUPPLIER ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17 follow-up in one week", record review lacked evidence that the attending physician or the designee re-evaluated the resident's condition in	RS FOR MEDICARE & MEDICAID SERVICES  OF DEFICIENCIES FORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085029  ROVIDER OR SUPPLIER  ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  follow-up in one week", record review lacked evidence that the attending physician or the designee re-evaluated the resident's condition in one week.  Review of the the meals percentage record from 11/25/08 at lunch through lunch on 11/29/08 (approximately 13 meals) revealed the resident consumed total of 240 cc of fluids during this four day period of time.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident had not taken any oral fluids for three days (11/26/08, 11/27/08, and 11/28/08), resident	RS FOR MEDICARE & MEDICAID SERVICES  TOF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085029  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17 follow-up in one week", record review lacked evidence that the attending physician or the designee re-evaluated the resident's condition in one week.  Review of the the meals percentage record from 11/25/08 at lunch through lunch on 11/29/08 (approximately 13 meals) revealed the resident consumed total of 240 cc of fluids during this four day period of time.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident had not taken any oral fluids for three days (11/26/08, 11/27/08, and 11/28/08), resident	ROVIDER OR SUPPLIER  ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  follow-up in one week", record review lacked evidence that the attending physician or the designee re-evaluated the resident's condition in one week.  Review of the the meals percentage record from 11/25/08 at lunch through lunch on 11/29/08 (approximately 13 meals) revealed the resident consumed total of 240 cc of fluids during this four day period of time.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident that and totaken any oral fluids for three days (11/26/08, 11/27/08, and 11/28/08), resident  (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET  GEORGETOWN, DE 19947  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOCK (EACH CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE APPR DEFICIENCY)  The Medical Director will be informed. Nurse manager or designee of any cha in condition as indicated in the Reside Status Change Policy and Procedure. Attachment 1/2.  Should the facility consult with an onphysician, any orders obtained will be communicated to the Medical Director the primary physician in a timely man ensure coordination of care.  All nursing staff will be inserviced on measures by 5/22/09  Four: Monitoring Mechanisms	TRENT OF HEALTH AND HUMAN SERVICES  RS FOR MEDICARE & MEDICAID SERVICES  RS FOR MEDICARE & MEDICAID SERVICES  OMB NO.  OF DEFICIENCIES F CORRECTION  OR SUPPLIER  ON HOUSE OF GEORGETOWN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  follow-up in one week", record review lacked evidence that the attending physician or the designee re-evaluated the resident's condition in one week.  Review of the the meals percentage record from 11/25/08 at lunch through lunch on 11/29/08 (approximately 13 meals) revealed the resident consumed total of 240 cc of fluids during this four day period of time.  Subsequent "24 hours Supervisory Report" dated 11/28/08 for the 3 PM to 11 Shift indicated resident taken any oral fluids for three days (11/26/08, 11/27/08, and 11/28/08), resident  To DEFICIENCY  STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  The Medical Director will be informed by the Nurse manager or designee of any change in condition as indicated in the Resident Status Change Policy and Procedure. Attachment Attachment Status Change Policy and Procedure. All nursing staff will be inserviced on these measures by 5/22/09  Four: Monitoring Mechanisms

and Depakote held. BP 82/68. (E7 was made aware of the above findings, however, the resident was not seen by the physician). E7 ordered to increase Remeron (medication to treat depression) from 7.5 mg. to 15 mg. daily at bedtime.

Further record review lacked evidence of any interventions and/or follow-up by the physician related to R2's condition as noted in the above supervisory report.

Nurse's note dated 11/29/08 time 1:30 PM documented resident unresponsive to verbal cues and touch, B/P 80/40, E7 was contacted and R2 sent to the hospital via 911.

Review of the hospital discharge summary indicated the following discharge diagnoses: 1. Acute renal failure with hypernatremia

- secondary to poor oral intake for four days. 2. Dehydration secondary to oversedation
- 3. Toxic encephalopathy with intolerance for

documentation report will continue to be conducted by the QI nurse or nursing supervisor to ensure compliance. Concerns will be immediately addressed. Results of the daily audit will be reported to the monthly and quarterly QI meeting for committee review.

On-going

PRINTED: 04/17/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
-110 I DIII O	. John Lorion		A. BUILD B. WING		j	5/2000
NAME OF P	ROVIDER OR SUPPLIER	085029		TREET ADDRESS, CITY, STATE,		5/2009
HARRISO	ON HOUSE OF GEOR	GETOWN		GEORGETOWN, DE 1994		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED I DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 501	Continued From paracotics.  Record review and	an interview with the facility's	F 50	)1		
	Medical Director du revealed that anoth in R2's care when it lethargic on 11/28/had not discussed hospital confineme interview with the Machine the facility lacked patandards including	aring the survey on 3/24/09 her physician, E7 was involved the resident was reported to be 08 and the medical director the events which led to the ont with E7. Additionally Medical Director revealed that policies pertaining to hydration g when to initiate close ent's intake and output and				
	The facility failed to (E5) in the coordin manner.	o involve the Medical Director ation of care for R2 in a timely				
				-		
·						

ENTERS FO	R MEDICARE & MEDICAID SERVICES			
	F ISOLATED DEFICIENCIES WHICH CAUSE H ONLY A POTENTIAL FOR MINIMAL HARM NFs	PROVIDER # 085029	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 3/25/2009
	TIDER OR SUPPLIER HOUSE OF GEORGETOWN	STREET ADDRESS, CIT 110 W. NORTH ST GEORGETOWN, I	REET	
EFIX G	SUMMARY STATEMENT OF DEFICIE	INCIES		
469	483.70(h)(4) PHYSICAL ENVIRONA  The facility must maintain an effective		•	rodents.
	This REQUIREMENT is not met as e Based on observations, record review, maintain an effective pest control prog 1. On 03/18/09 at 10:17 AM, approxistand of room #48, door side. Review room #49 had been treated for ants. For at least one ant remained in room #48 facility to return for additional service.  2. On 03/25/09 at about 11:20 AM, approxistand of room #48, door side. Addition of room #48, window side. After brief second time about the issue.	and staff interview, it ram so that the facility mately one dozen smal of the pest control cor ollow-up interview wit on 03/23/09 and that the proximately six small mally about fifteen an	l ants were observed on and around the staff on 03/24/09 indicated that staff expest control contractor was contact ants were observed on and around the swere observed on the chair rail, wall	ne bed side on 03/16/09 If observed ed by the bed side and ceiling
	director, Mike Trolan to	hat their services a d new pest control ervice 2 times a m	acted by maintenance re no longer needed as company A.P.M upgrade onth and 4 hour response	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



AND SOCIAL SERVICES DELAWARE HEALTH

Division of Long Term Care Residents Protection

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(302) 577-6661

LTC Residents Protection Director's Office APR 2 8 2009

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3-25-09

DATE SURVEY COMPLETED:

STATE SURVEY REPORT

NAME OF FACIL	NAME OF FACILITY: Harrison House of Georgetown	DAIE SURVET COMPLETED. SESSE
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal	Disclaimer Statement
	Report.	Preparation and /or execution of the
	An unannounced annual and complaint visit was	Plan of Correction does not constitute admission or agreement of the provider
	conducted at this facility March 18, 2009 through	of the truth of the facts alleged or
	March 25, 2009. The facility census on the first	of Deficiencies. The Plan of Correction
	day of the survey was offe-fluidied four (104).	is prepared and /or executed solely

This plan represents the facility's credible because it is required by the provisions is prepared and /or executed solely of federal and state law.

The deficiencies contained in this report are based

on observations, interviews, review of residents'

documentation as indicated. The survey sample

clinical records and review of other facility

active and three (3) closed records respectively. There was a sub-sample of five (5) residents for

observation and interview that was not in the

sample for complete record review.

totaled twenty-one (21) residents, eighteen (18)

allegation of compliance as of 6/01/09.

60/10/9

3201 Skilled and Intermediate Care Nursing Facilities

Skilled and Intermediate Care Nursing Facilities

3201.5.0 Personnel/Administrative

implementation of resident care policies and 3201.5.3 The designated Medical Director the coordination of medical care in the will continue to be responsible for facility

> responsible for implementation of resident care policies and the coordination of medical care in

This requirement is not met as evidenced by:

to serve as the medical director who shall be

The nursing facility shall designate a physician

3201.5.3

3201.5.0

3201

Personnel/Administrative

Cross refer to the CMS 2567-L report date completed 3/25/09, F501.



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DATE SURVEY COMPLETED: 3-25-09

NOTUE	STATEMENT OF DEFICIENCIES	ADMINIST	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH
	Specific Deficiencies		ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal	F 501	483.75(i) Medical Director
	Report.		Cross-refer to F327
	An unannounced annual and complaint visit was conducted at this facility March 18, 2009 through March 25, 2009. The facility census on the first		The facility will continue to consult with the Medical Director with regards to the coordination
	day of the survey was one-hundred four (104). The deficiencies contained in this report are based on observations, interviews, review of residents'		To address survey concerns the facility is taking the following measures:
	clinical records and review or other racility documentation as indicated. The survey sample totaled twenty-one (21) residents, eighteen (18)		One: Corrective action for situation identified
	active and three (3) closed records respectively.  There was a sub-sample of five (5) residents for observation and interview that was not in the		The facility recognizes that there is no further corrective action with regards to medical follow-up, physician consultation or assessment of R2 from
3201	Skilled and Intermediate Care Nursing Facilities		11/19/09 to 11/28/09. On 11/28/09, the on-call physician was notified of the resident's condition.
3201.5.0	Personnel/Administrative		Two: Identification of other residents that have the potential to be affected
3201.5.3	The nursing facility shall designate a physician to serve as the medical director who shall be responsible for implementation of resident care policies and the coordination of medical care in the facility.		The facility recognizes that all residents have the potential to be affected by timely medical follow-up and coordination. Daily reviews of the 24 hour report by the QI nurse or nurse supervisor will ensure that a resident's condition has been evaluated by the physician and timely follow-up has occurred and is
	This sections to not mot so ovidenced hu.		documented. 5/22/09

This requirement is not met as evidenced by:



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### STATE SURVEY REPORT

DATE SURVEY COMPLETED: 3-25-09

			UTIN GRICKLICHT TO THE STATE OF	
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRA	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ADMINISTRATED DATES TO BE CORRECTED	
	The State Report incorporates by reference and	F 501	Three: Measures or systemic changes	
			Physician's orders and progress notes	
	Kepol:		will be reviewed by the unit nurse. Any resident	
	An inappropried and and complaint visit was		to the Medical Visit Follow-up List located	
	conducted at this facility March 18, 2009 through		in the physician's notebook.	•
	March 25, 2009. The facility census on the first		This procedure will ensure that the physician is notified of the need for a resident visit and	
	day of the survey was one-hundred four (104).		assessment.	
	The deficiencies contained in this report are based		Attachment C	
	on observations, interviews, review of residents			
	clinical records and review of other facility		The Medical Director will be informed by the	
	documentation as indicated. The survey sample		Nurse manager or designee of any change	
_,	totaled twenty-one (21) residents, eighteen (18)		in condition as indicated in the Nesident Sector Change Polity and Procedure.	
			Attachment A	
			How we are delined the second to the second	
	observation and interview that was not in the		Should the facility consult with an on-call	
	sample for complete record review.		communicated to the Medical Director or	
			the primary physician in a timely manner to	
3201	Skilled and Intermediate Care Nursing Facilities		ensure coordination of care.	
			All nursing staff will be inserviced on these	
3201.5.0	Personnel/Administrative		measures by 5/22/09	
2204 53	The nursing facility shall designate a physician		Four: Monitoring Mechanisms	
	to serve as the medical director who shall be		The daily review of the 24 hour nursing	
•	responsible for implementation of resident care		documentation report will continue to be conducted by the QI nurse or nursing	
	g the coordination of		supervisor to ensure compliance. Concerns	
	the facility.		will be immediately addressed. Results of the daily audit will be reported to the monthly On-going	
	This requirement is not met as evidenced by:		and quarterly QI meeting for committee	
			Tours.	



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DATE SURVEY COMPLETED: 3-25-09

# NAME OF FACILITY: Harrison House of Georgetown

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATO	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F501.		
3201.6.0	Services to Residents:		3201.6.0 Services to Residents
3201.6.1	General Services:		3201.6.1 General Services
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.	·	3201.6.1.1 The nursing facility shall continue to provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.
	This requirement is not met as evidenced by:		Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		F329.
		F 157	483.10 (b) (11) Notification of Changes
3201.6.9	Housekeeping and Laundry Services		The facility will immediately consult with the resident's physician in the event of a
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility		significant change in the resident's physical, mental or psychosocial status.
	is free of live insects and other vermin.		To address survey concerns the facility is taking the following measures:
	This requirement is not met as evidenced by:		

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n House of Georgetown	
FACILITY: Harrison	
NAME OF	

	STATEMENT OF DETICIENCIES Specific Deficiencies		ANTICIPATED DATES TO BE CORRECTED	
	Cross refer to the CMS 2567-L survey report date	F 157	One: Corrective action for situation identified	
	completed 3/25/09, F501.		The facility recognizes that there is no corrective action for the concern identified for R2 from 11/25/09 to 11/27/09. The facility	
3201.6.0	Services to Residents:		has continued to consult, in a timely manner. with the resident's physician with regards to the resident's condition.	
3201.6.1	General Services:		Two: Identification of other residents	
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		The facility recognizes that all residents have the potential to be affected with regards to immediate physician notification in the event of a change in condition. Daily the QI nurse or the nurse supervisor reviews the Nurse 24 hour report and nursing documentation.	
	This requirement is not met as evidenced by:		to ensure that the physician has occur interior for any resident status change.	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		Three: Measures or systemic changes	
3201.6.9	Housekeeping and Laundry Services		In addition to the daily review by the QI nurse or supervisor of changes in resident condition or status, the policy and procedure has been undated, in accordance with F tag 157. All	
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.	>	nursing staff will be inserviced on the Change in Resident Status Policy and Procedure by \$122/09.	8/22/09
	This requirement is not met as evidenced by:	····		



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## NAME OF FACILITY: Harrison House of Georgetown

NAME OF PACILI			HIM SELVENCIED SE DEFICIENCIES WITH
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRAT	ADMINISTRATOR'S PLAN FOR CORRECTION OF DETICE STATES ANTICIPATED DATES TO BE CORRECTED
		F 157	Four: Monitoring Mechanisms
	completed 3/25/09, F501.		The QI nurse will continue to audit resident records to ensure compliance with regards to timely physician notification
3201.6.0	Services to Residents:		and follow up. Concerns will be reported to the nurse manager who will take the appropriate measures in accordance with facility policy.
3201.6.1	General Services:		the monthly and quarterly QI meeting.
3201.6.1.1		F 327	483.25(j) Hydration
	safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		The facility will continue to ensure that all residents are provided with sufficient fluid intake to maintain proper hydration and
<del></del>	This requirement is not met as evidenced by:		health, identify those at risk for dehydration and respond in a timely manner to inadequate fluid intake which could result in a change in
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		condition.  To address survey concerns the facility is taking the following measures:
3201.6.9	Housekeeping and Laundry Services		One: Corrective Action for situation identified
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.		The facility recognizes that there is no corrective action for the concerns identified. However upon R2s return to the facility the following measures were implemented: Care plan for risk for dehydration, Intake and
	This requirement is not met as evidenced by:		Output, medication review by physician, Speech and OT evaluation for swallow and feeding, Psych evaluation for behaviors and
			medication review and consultant ritatinacist review.

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### STATE SURVEY REPORT

NAME OF FACILIT	NAME OF FACILITY: Harrison House of Georgetown	DATE SURVEY C	DATE SURVEY COMPLEIED: 3-23-23
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	N OF DEFICIENCIES WITH
		F 327 Two: Identification of other residents that	nts that
	Cross refer to the CMS 2567-L survey report date	The facility recognizes that all residents have	nts have '
		the potential to be affected by the risk related to insufficient fluid intake, dehydration and	k related on and
2000	Services to Residents:	timely care intervention. Continued review of the daily 24 hour report	ır report
0.0.1026		and facility documentation by the	ulted in
3201.6.1	General Services:	the timely identification of any resident at risk and the implementation of appropriate	ent at priate
2204 6 1 1	The nursing facility shall provide to all	interventions.	
	residents the care necessary for their comfort,	Three: Measures or systemic changes	-
	their medical, nursing, nutritional, and psychosocial needs.	To address the survey concerns the facility is implementing the following Policies and Procedures by \$722/09:	acility is and
	This requirement is not met as evidenced by:	1. HYDRATION RISK ASSESSMENT HYDRATION RISK EVALUATION	ION
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.	Attachment 6	
		2. CHANGE IN RESIDENT STATUS Cross reference POC F 157	US .
3201.6.9	Housekeeping and Laundry Services	Attachment A	
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live inserts and other vermin.	3. MEDICAL VISIT/FOLLOW-UP LIST Cross reference POC F 501	LIST
		Attachment C	
	This requirement is not met as evidenced by:		



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DATE SURVEY COMPLETED: 3-25-09

f Georgetown	
Harrison House o	
JAME OF FACILITY:	

NAME OF PACIFIC .		N SEICIENCIES IN	HIM
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCES	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F501.	F 327 4. INTAKE MONITORING DAILY MEAL MONITORING TEMPORARY CARE PLAN Inadequate Intake	90/22/8
		Attachment D	} 
3201.6.0	Services to Residents:	To address meal monitoring and early	
3201.6.1	General Services:	intervention the nursing staff was inserviced on a Daily Meal Monitoring Policy and form by 4/7/09. The Policy and Procedure was	
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort,		. 60//04
	safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.	In order to accurately include and document all sources of intake the facility is implementing updated CNA and Nurse	
	This requirement is not met as evidenced by:	immediately.  Attachment	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.	Nursing and CNA staff were inserviced on the Intake and Output forms by 4/6/09 Attachment	4/06/09
3201.6.9	Housekeeping and Laundry Services	To address the Dietary Referral: A DIETARY COMMUNICATIONS BOOK	
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.	will contain all requests for a Dietician Consultation which the Dietician, QI nurse and/or the nurse manager will review twice a week . All requests will be signed by the Dietician and returned to the book. The book	
	This requirement is not met as evidenced by:	will also contain meal % sheets for reference. This measure will assist in ensuring the maintenance of proper hydration. This is	
		Clickly inninctially.	3

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DATE SURVEY COMPLETED: 3-25-09

NAME OF FACILIT	NAME OF FACILITY: Harrison House of Georgetown		DATE SURVEY COMPLETED: 3-28-38	
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRAT	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	WITH
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F501.	F 327	The RNAC COMMUNICATION FORM will continue to be utilized whenever a change in care level or care interventions has occurred. This will ensure accurate and timely care planning documentation.	
	or in the Dool donte.		Attachment H	····
3201.6.0	General Services:		All nursing services staff will be inserviced on the above Policies and Procedures by \$/22/09.	5/03
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort,		Four: Monitoring Mechanisms:	
	safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		Unit manager or designee will be responsible for the daily monitoring of resident care and the timely consultation with the physician of any change of condition. The unit manager or	
	This requirement is not met as evidenced by:		designee will continue to report to the interdisciplinary team the daily resident condition utilizing the nurse 24 hour report.	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		The QI nurse will continue to audit the daily 24 hour report and any pertinent nursing documentation. Any identified concerns will be addressed immediately and reported the	
3201.6.9	Housekeeping and Laundry Services		ADON who will ensure compliance. Weekend supervision by a nurse manager will continue to assist in the provision of quality, timely care.	
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.		ts will be reported to the rly QI committee.	On-going
	This requirement is not met as evidenced by:			+

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	HIM SEICIENCIES MITH	ADMINISTRATOR'S PLAN FOR CORRECTION OF CLICATION AND ANTICIPATED DATES TO BE CORRECTED	
MASSE OF EACH ITV. Marrison House of George Cown		ENCIES	Specific Deficiencies

		F 329	483.25(i) Unnecessary Drugs
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F501.		The facility will continue to ensure that residents are free from unnecessary drugs.
			Cross refer F327
3201.6.0	Services to Residents:		One: Corrective action for situation identified
3201.6.1	General Services:		The facility recognizes that there is no further corrective action for the concerns identified
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		during the period prof to KZ flospitalization. Upon return to the facility form the hospital the following measures were initiated:  1. Physician medication review 2. Pharmacy medication review 3. Advance directive-no tube feeding 4. Dictician review-12/11/08 5. Psychiatric Nurse consultation-
	This requirement is not met as evidenced by:		1/09/09 6. Comprehensive Lab work completed and reviewed by physician
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		7. TCP initiated to include weight loss and lethargy 8. Inservice Training on "Nutrition and Dementia" 1/19/09
3201.6.9	Housekeeping and Laundry Services		Two: Identification of other residents that have the potential to be affected
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.		The facility recognizes that all residents have the potential to be affected with regards to ensuring that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral
	This requirement is not met as evidenced by:		interventions, unless clinically contraindicated. in an effort to discontinue these drugs.



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NAME OF FACILI	NAME OF FACILITY: Harrison House of Georgetown	DAIE SORVET COMPLETE:
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		Three Meaning or systemic changes
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F501.	F 329  A Temporary Care Plan (TCP) will be initiated to monitor residents who are having decreased intake, (utilizing the Daily Resident Meal Monitoring Form) and are on a psychotropic medication Effective Immediately.
3201.6.0	Services to Residents:	Attachment D
3201.6.1	General Services:	A TCP will be initiated for residents who are starting the use of a new psychotropic
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and	medication or an adjusted dosage of psychotropic medication, to monitor tolerance to a new or adjusted dosage, level of consciousness, and overall side effects of newly sed or adjusted psychotropic medications.
	psychosocial needs.  This requirement is not met as evidenced by:	The consultant pharmacist will be informed of residents with decreased intake and will be requested to conduct a psychotropic medication review. The monthly and quarterly
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.	"Psychotropic Drug Usage Report" conducted by the QI nurse will be modified and will provide more detailed information to include names of residents using two or more psychotropic medications.
3201.6.9	Housekeeping and Laundry Services	The use of the "Hydration Risk Assessment" will be continued.
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.	Attachment 2.7.7  Attachment 2.7.7  The use of the Behavior/Intervention monthly  Flow Record and the Behavior Logs will be
	This requirement is not met as evidenced by:	Attachments 7 and K On-going
		No.

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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	r 200 The following inservice training will be
ECTION STATEMENT OF DEFICIENCIES Specific Deficiencies	

	Cross refer to the CMS 2567-L survey report date	F 329	The following inservice training will be conducted by 5/29/09:	
	completed 3/25/09, F501.		1. "Psychotropic Medication and Side effects" Medical Director	
3201.6.0	Services to Residents:		Record" Inservice Coordinator  "CNA use of the Behavior Logs"  Inservice Coordinator	8/29/09
3201.6.1	General Services:			
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		Four: Monitoring Mechanisms:  The usage and effectiveness of the new TCP tools will be monitored daily by the QI Nurse, nurse managers, and staff nurses. Corrective action will be implemented immediately, if needed. A retrospective daily documentation audit by the QI Nurse will be conducted for any conduction and the QI Nurse will be conducted for the QI Nurse will be conducted to the province for the QI Nurse will be conducted to the province for the QI Nurse will be conducted to the province for the QI Nurse will be conducted to the province for the province	
	This requirement is not met as evidenced by:		evaluate the documentation by the nutshing stati of residents with decreased intake and receiving psychotropic medications. Concerns will be	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F157, F327, and F329.		reported to the individual nurse immediately, the nurse manager within 24 hours and to the QI Committee on a monthly and quarterly basis.	On-going
3201.6.9	Housekeeping and Laundry Services	·	3201.6.9 Housekeeping and Laundry Services	
3201.6.9.6	The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.		3201.6.9.6 The facility will continue to contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.	
	This requirement is not met as evidenced by:		Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	



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NAME OF FACILITY: Harrison House of Georgetown

NAME OF FACILIT	NAME OF FACILITY: Harrison House of Georgetows		HIM SHICK OF DESIGNING WITH
SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRA	ADMINISTRATOR'S PLAN FOR CORRECTION OF DETICIONAL ADMINISTRATOR DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	F 469	To address survey concerns the facility is undertaking the following measures:
2201 G 12	Communicable Diseases		One: Action taken for situation identified
3201.6.12.3	Immunizations	<u>.</u>	Ants located in room #48 were treated on 4/03/09 by Orkin Pest Control. On 4/04/09,
3201.6.12.3.3	A resident who refuses to be vaccinated		was again notified. Orkin Pest Control did 4/03/09 not respond with in 24 hours.
			Two: Identification of other residents who have the potential to be affected
	shall be documented in the resident a medical record annually.		The facility recognizes that all residents have the potential to be affected with regards to a
	This requirement is not met as evidenced by:		pest free environment. The facility will On-going continue to maintain a sanitary and pest free
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F334.		environment.  Three: Measures or systemic changes
			The contract with Orkin Pest Control was 4/07/09 terminated effective 4/07/09. The facility
			contracted with A.P.M. who will upgrade the services to twice monthly and will respond within 4 hours. Effective 4/08/09.

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	Secondary Definiencies	ANT	ANTICIPATED DATES TO BE CORRECTED	ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	F469 Four	Four: Monitoring Mechanisms	
		All co	All concerns will be addressed immediately	
1		ey un	by the maintenance department. The response time for service will be four hours.	
3201.6.12	Communicable Diseases	The r	The maintenance director or designee will	
3201.6.12.3	Immunizations	exter	exterior of the facility to ensure the facility is	
3201.6.12.3.3	A resident who refuses to be vaccinated	immi obset	ed at	On-going
	shall be informed by the facility of the health risks involved. The reason for the refusal(s)			
	shall be documented in the resident's medical	3201	3201.6.12 Communicable Diseases	
		3201	3201.6.12.3 Immunizations	
	This requirement is not met as evidenced by:	3201	3201.6.12.3.3 A resident who refuses to be	
	Cross refer to the CMS 2567-L survey report date	vacci	vaccinated against influenza or pneumococcal pneumonia will be informed	
	completed 3/25/09, F334.	by th	by the facility of the health risks involved.  The reason for the refusal (s) will be	
		documen	documented in the resident's medical record annually.	
		Cros	Cross refer to the CMS 2567-L survey report	



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	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
NAME OF FACILITY: Harrison House of Georgetown		Specific Denciencies

Communicable Diseases  Immunizations  A resident who refuses to be vaccinated against influenza or pneumococcal pneumonia shall be informed by the facility of the health risks involved. The reason for the refusal(s) shall be documented in the resident's medical record annually.  This requirement is not met as evidenced by:  Cross refer to the CMS 2567-L survey report date completed 3/25/09, F334.  Cross refer to the commission of the concern residents on each of the residents in the resident of the resident of the concern resident in the resident of the concern.  Cross refer to the CMS 2567-L survey report date influenza immunization were celucated or faking the influenza immunization. The documentation was provident on each of the resident's believes that the resident is the resident of the concern.  Cross refer to the CMS 2567-L survey report date influenza immunization were celucated or faking the influenza immunization. The documentation was provident on the resident or the residents in the resident or the resident or the residents against through the residents agai		Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	F 334	483.25(n) Influenza and Pneumococcal Immunizations	
against influenza or pneumococcal pneumonia shall be informed by the facility of the health risks involved. The reason for the resident's medical record annually.  This requirement is not met as evidenced by:  Cross refer to the CMS 2567-L survey report date completed 3/25/09, F334.  A resident who refused prepresentative was provided education to benefits and potential side effects of the influenza immunization of the concern.  Upon identification of the concern.  Upon identification of the concern.  Upon identification of the concern.  Cross refer to the CMS 2567-L survey report date influenza immunization. The documentation was entered on each of the resident's Educational Record.	1.6.12	Communicable Diseases Immunizations		The facility will continue to ensure through policies and procedures that the residents' medical record includes documentation that indicates that the resident or the	
To address survey concerns the facility is taking the following measures:  One: Corrective Action for situation Identified  Upon identification of the concern.  residents R4, R8, and R21 who refused the influenza immunization were educated by the nurse manager about the benefits of taking the immunization. The documentation was entered on each of the resident's Educational Record.	3201.6.12.3.3	A resident who refuses to be vaccinated against influenza or pneumococcal pneumonia		resident's legal representative was provided education regarding the benefits and potential side effects of the influenza immunization.	
CMS 2567-L survey report date  9, F334.  Unertified  Upon identification of the concern.  residents R4, R8, and R21 who refused the influenza immunization were educated by the nurse manager about the benefits of taking the immunization. The documentation was entered on each of the resident's Educational Record.		risks involved. The reason for the refusal(s) shall be documented in the resident's medical record annually.		To address survey concerns the facility is taking the following measures:	
Upon identification of the concern. residents R4, R8, and R21 who refused the influenza immunization were educated by the nurse manager about the benefits of taking the immunization. The documentation was entered on each of the resident's Educational Record.		This requirement is not met as evidenced by:		One: Corrective Action for situation Identified	
		Cross refer to the CMS 2567-L survey report date completed 3/25/09, F334.		Upon identification of the concern. residents R4, R8, and R21 who refused the influenza immunization were educated by the nurse manager about the benefits of taking the immunization. The doc-	
				umentation was entered on each of the resident's Educational Record.	3/19/09

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NAME OF FACILIT	NAME OF FACILITY: Harrison House of Georgetown		DATE SURVEY COMPLETED: CLOSE	
SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRA	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	E
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	F 334	Two: Identification of other residents that have the potential to be affected	
			After conducting a record audit, the facility recognized that seven additional residents	
3201.6.12	Communicable Diseases		were affected with regards to the document the educational portion of the influence immunitation refusal. All	
3201.6.12.3	Immunizations		residents were educated and the documentation was entered in the medical 3/19/09	60/
2204 6 42 3 3	A resident who refuses to be vaccinated		record.	
3201.6.12.3.3	against influenza or pneumococcal pneumonia		Three: Measures or systemic changes	
	shall be informed by the facility of the health risks involved. The reason for the refusal(s)		The Immunization Consent forms will be added to the Nurse Admission Packet.	
	shall be documented in the resident's medical		The admitting nurse will be responsible for reviewing the risks and benefits of	
	record annually.		immunizations. On a yearly basis the	
	This requirement is not met as evidenced by:	-	re-educated utilizing the Influenza re-educated utilizing the Consent form.	
	CMS 2567-L survey report date		Attachments C and M	
	completed 3/25/09, F334.		In the event of an immunization refusal, the facility will continue to document	
		<del></del>	ects	
			of the immunization. 3/25/09	60/
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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F469.	F 334 Four: Monitoring Mechanisms: An inservice will be provided to educate the
3201.6.12	Communicable Diseases	Nursing staff on the utilization of the Influenza and Pneumococcal Immunization Consent forms and the Immunizations Policy and Procedure by April 30, 2009. Monthly
3201.6.12.3	Immunizations	و
3201.6.12.3.3	A resident who refuses to be vaccinated against influenza or pneumococcal pneumonia shall be informed by the facility of the health risks involved. The reason for the refusal(s) shall be documented in the resident's medical record annually.	will be reported at the monthly and quarterly QI meeting. Any immediate concerns will be corrected immediately and reported to the ADON who will ensure compliance.  Attachment A
	This requirement is not met as evidenced by:	
	Cross refer to the CMS 2567-L survey report date completed 3/25/09, F334.	

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